

940 - MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

EFFECTIVE DATES: 10/01/94, 01/25/19

APPROVAL DATES: 07/01/16, 10/01/15, 03/01/14, 10/01/13, 04/01/12, 02/01/11, 10/01/09,
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01/23/19

1. Contractors shall have policies and procedures in place for use of electronic medical (physical and behavioral health) records and for use of an health information exchange (including electronic Early and Periodic Screening, Diagnosis and Treatment (EPSDT) tracking forms) and digital (electronic) signatures (when electronic documents are utilized) that include processes for:
 - a. Signer authentication,
 - b. Message authentication,
 - c. Affirmative act,
 - d. Efficiency, and
 - e. Record review.
2. Contractors shall implement appropriate policies and procedures to ensure that the organization and its providers have information required for:
 - a. Effective and continuous member care through accurate medical record documentation (including electronic health records) of each member's health status, changes in health status, health care needs, and health care services provided,
 - b. Quality review,
 - c. Coordination of care, and
 - d. An ongoing program to monitor compliance with those policies and procedures. If during the quality of care review process, or other processes, issues are identified with the quality or content of a provider's medical record, the Contractor shall conduct a focused review, implement corrective actions or other remedies until the provider's medical records process meets standards specified in the AMPM.
3. Contractors shall implement policies and procedures for initial and on-going monitoring of medical records.
4. Contractors may utilize Arizona Association of Health Plans (AzAHP) to conduct medical record reviews. AzAHP serves as an association of contracted AHCCCS health plans organizes to bring exemplary health care – at the lowest possible cost – to the 1.9 million Arizonans enrolled in the AHCCCS program.
5. The following methodology shall be utilized:
 - a. Conduct Medical Record Reviews using a standardized tool that has been reviewed by AHCCCS. The tool shall include but is not limited to EPSDT, family planning and maternity components not otherwise monitored for provider compliance by Contractors,

- b. Conduct medical records reviews at a minimum of every three years,
 - c. Utilize a collaborative approach (use of a vendor by AzAHP) is acceptable that will result in only one medical record review for each provider. Use of a vendor would be considered a delegated arrangement,
 - d. Results of the medical record review will be made available to all Contractors who utilize AzAHP for this process and that contract with the audited provider,
 - e. Deficiencies identified shall be shared with all health plans contracted with the provider,
 - f. If quality of care issues are identified during the medical record review process, it is expected that all health plans that contract with that provider be notified promptly (within 24 hours) in order to conduct an independent on-site provider audit,
 - g. Providers to be included in the medical record review process shall include all primary care providers that serve children (children defined as under 21 years of age) and obstetricians/gynecologists. The review process will include the following, unless a different methodology is reviewed and approved by AHCCCS:
 - i. The review process shall consist of reviewing eight charts per practitioner,
 - ii. If the score after eight charts is less than 90 percent, technical assistance shall be provided to the practitioner,
 - iii. If the score after eight charts is less than 90 percent, the practitioner shall also be re-audited the following year, and
 - iv. If the score after eight charts is 90 percent or greater, yet areas of deficiency are found, technical assistance shall be provided to the practitioner.
 - h. For providers that do not treat children, the following process shall occur unless a different methodology is reviewed and approved by AHCCCS:
 - i. A random sample of 30 providers per Geographic Service Area (GSA) will be pulled for audit each year. Eight charts will be audited per provider,
 - ii. If the score after eight charts is less than 90 percent, technical assistance shall be provided to the provider,
 - iii. If the score after eight charts is less than 90 percent, the provider shall also be re-audited the following year,
 - iv. If the score after eight charts is 90 percent or greater, yet areas of deficiency are found, technical assistance shall be provided to the provider, and
 - v. If, after all the audits are completed and noted trends are identified around deficiencies or improvement opportunities, the entire network shall receive education and guidance on the issues identified.
6. Each Contractor shall implement policies and procedures that address paper and electronic health records, and the methodologies to be used by the organization to:
- a. Ensure that contracted providers maintain a legible medical record (including electronic health record/medical record) for each enrolled member who has been seen for medical or behavioral health appointments or procedures. The medical record shall also contain clinical/behavioral health records from other providers who also provide care/services to the enrolled member,
 - b. Ensure providers, in multi-provider offices, have the treating provider sign his or her treatment notes after each appointment and/or procedure. Progress notes shall be documented on the date the event occurs. Any additional information added to

progress notes shall be identified as a late entry and dated accordingly. Additionally, behavioral health provider signatures shall include the provider's credentials as part of the signature,

- c. Ensure the medical record contains documentation of referrals to other providers, coordination of care activities, and transfer of care to behavioral health and other providers,
- d. Make certain the medical record is legible, kept up-to-date, is well organized and comprehensive with sufficient detail to promote effective patient care, quality review, and identifies the treating or consulting provider. A member may have more than one medical record kept by various health care providers that have rendered services to the member. However, the PCP shall maintain a comprehensive record that incorporates at least the following components:
 - i. Behavioral health information when received from the behavioral health provider about an assigned member even if the provider has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but shall be associated with the member's medical record as soon as one is established,
 - ii. Member identification information on each page of the medical record (i.e., name or AHCCCS identification number),
 - iii. Documentation of identifying demographics including the member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative,
 - iv. Initial history for the member that includes family medical history, social history and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member),
 - v. Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance use, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received,
 - vi. Immunization records (required for children; recommended for adult members if available),
 - vii. Dental history if available, and current dental needs and/or services,
 - viii. Current problem list,
 - ix. Current medications,
 - x. Documentation of review of the Controlled Substances Prescription Monitoring Program (CSPMP) data base prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances,
 - xi. Current and complete EPSDT forms (required for all members age 0 through 20 years),
 - xii. Developmental screening tools for children ages nine, 18 and 24 months,
 - xiii. Documentation, initialed by the member's provider, to signify review of:
 - (a) Diagnostic information including:
 - (i) Laboratory tests and screenings,

- (ii) Radiology reports,
 - (iii) Physical examination notes, and
 - (iv) Other pertinent data.
 - (b) Reports from referrals, consultations and specialists,
 - (c) Emergency/urgent care reports,
 - (d) Hospital discharge summaries,
 - (e) Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed, and
 - (f) Behavioral health history and behavioral health information received from a Regional Behavioral Health Authority (RBHA) or RBHA provider who is also treating the member.
- xiv. Documentation as to whether or not an adult member has completed advance directives and the location of the document,
- xv. Documentation that the provider responds to behavioral health provider information requests within 10 business days of receiving the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit, and recent hospitalizations. Documentation shall also include the provider's initials signifying review of member behavioral health information received from a behavioral health provider who is also treating the member,
- xvi. Documentation related to requests for release of information and subsequent releases, and
- xvii. Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the provider including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.
- d. Ensure that obstetric providers complete a standardized, evidence-based risk assessment tool for obstetric members (i.e. Mutual Insurance Company of Arizona [MICA] Obstetric Risk Assessment Tool or American College of Obstetricians and Gynecologists [ACOG]). Also, ensure that lab screenings for members requiring obstetric care conform to ACOG guidelines,
- e. Ensure that PCPs utilized AHCCCS approved developmental screening tools,
- f. Ensure each organizational provider of services (e.g., hospitals, nursing facilities, rehabilitation clinics, transportation) maintains a record of the services provided to a member, including:
- i. Physician or provider orders for the service,
 - ii. Applicable diagnostic or evaluation documentation,
 - iii. A plan of treatment,
 - iv. Periodic summary of the member's progress toward treatment goals,
 - v. The date and description of service modalities provided, and
 - vi. Signature/initials of the provider for each service.
- g. Ensure that RBHA transportation services that utilize provider employees (e.g. facility vans, drivers, etc.) maintain documentation that supports each transport provided. The follow information shall be documented to verify transportation services:

- i. Complete service provider's name and address,
 - ii. Signature and credentials of the driver who provided the service,
 - iii. Vehicle identification (car, van, wheelchair van, etc.),
 - iv. Members' AHCCCS identification number,
 - v. Date of service, including month day and year,
 - vi. Address of pick up site,
 - vii. Address of drop off destination,
 - viii. Odometer reading at pick up,
 - ix. Odometer reading at drop off,
 - x. Type of trip – round trip or one way,
 - xi. Escort (if any) shall be identified by name and relationship to the member being transported, and
 - xii. Signature of the member, parent and/or guardian/caregiver, verifying services were rendered including documentation by the driver of refusal by a member to sign.
 - h. Take into consideration professional and community standards and accepted and recognized evidence-based practice guidelines,
 - i. Ensure the Contractor has an implemented process to assess and improve the content, legibility, organization, and completeness of member health records when concerns are identified, and
 - j. Require documentation in the member's record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants or para professionals provide services.
7. Medical records may be documented on paper or in an electronic format:
- a. If records are documented on paper, they shall be written legibly in blue or black ink, signed, and dated for each entry. Electronic format records shall also include the name of the provider who made the entry and the date for each entry,
 - b. If records are physically altered, the stricken information shall be identified as an error and initialed by the member altering the record along with the date when the change was made; correction fluid or tape is not allowed,
 - c. If kept in an electronic file, the provider shall establish a method of indicating the author, date, and time of added/revised information and a means to assure that information is not altered inadvertently,
 - d. If revisions to information are made, a system shall be in place to track when, and by whom, they are made. In addition, a backup system including initial and revised information shall be maintained,
 - e. Medical record requirements are applicable to both hard copy and electronic medical records. Contractors may go on site to review the records electronically or utilize a secure process to review electronic files received from the provider when concerns are identified. Safeguards shall be in place to ensure that only authorized individual are able to access medical records.

8. Each Contractor shall have written policies and procedures addressing appropriate and confidential exchange of member information among providers, including behavioral health providers, and shall conduct reviews to verify that:
 - a. A provider making a referral transmits necessary information to the provider receiving the referral,
 - b. A provider furnishing a referral service reports appropriate information to the referring provider,
 - c. Providers request information from other treating providers as necessary to provide appropriate and timely care,
 - d. Information about services provided to a member by a non-network provider (e.g. emergency services) is transmitted to the member's PCP,
 - e. Member records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP,
 - f. Member information is shared, when a member subsequently enrolls with a new Contractor, in a manner that maintains confidentiality while promoting continuity of care, and
 - g. Member information is shared within 10 business days with behavioral health providers and, as appropriate, other providers or entities involved in the member's care for members with ongoing care needs or changes in health status.
9. Information from, or copies of, records may be released only to authorized individuals, and the Contractor shall implement a process to ensure that unauthorized individuals cannot gain access to, or alter, member records.
10. Original and/or copies of medical records shall be released only in accordance with Federal or State laws and AHCCCS policy and contracts. Contractors shall comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 et seq.
11. Medical records retention shall align with AHCCCS Contract and TRBHA Intergovernmental Agreement (IGA) requirements. The maintenance and access to the member's medical record shall survive the termination of a provider's contract regardless of the cause of termination.
12. Contractors shall participate/cooperate in State of Arizona and AHCCCS activities related to the development and implementation of electronic health records and e-prescribing. Electronic EPSDT tracking forms shall include all elements of the AHCCCS approved EPSDT tracking forms.
13. Contractors may request approval to discontinue conducting medical record reviews. Prior to receiving approval to discontinue the medical record review process, the Contractor shall:
 - a. Conduct a comprehensive review of its use of the medical record review process and how it is used to document compliance with AHCCCS requirements such as EPSDT, family planning, maternity and behavioral health services,

- b. Document what processes will be used in place of the medical record review process to ensure compliance with AHCCCS requirements,
 - c. Submit the process the Contractor will utilize to ensure provider compliance with AHCCCS medical record requirements to the AHCCCS Clinical Quality Management Administrator prior to discontinuing the medical record review process, and
 - d. Refer to AMPM Policy 640 and AHCCCS Contract for a complete discussion on Advanced Directives for adult members.
14. Behavioral Health Medical Record Requirements shall include the following elements:
- a. Initial evaluation that includes:
 - i. Documentation of the member's receipt of the Member Handbook and receipt of Notice of Privacy Practice,
 - ii. Contact information for the member's Primary Care Provider; for members receiving substance use treatment services under the Substance Abuse Prevention & Treatment Block Grant (SABG), documentation that notice was provided regarding the member's right to receive services from a provider to whose religious character the member does not object. See AMPM Policy 320-T, Exhibit 320-9 for Notice requirements, and
 - b. For Non-Title XIX/XXI members receiving behavioral health services:
 - i. Financial documentation that includes:
 - ii. Documentation of the results of a completed Title XIX/XXI screening at initial evaluation appointment, when the member has had a significant change in his/her income, and at least annually
 - iii. Information regarding establishment of any copayments assessed, if applicable
 - c. Assessment documentation that includes:
 - i. Documentation of all information collected in the behavioral health assessment, any applicable addenda and required demographic information (see AMPM Policy 580, AMPM Policy 320-O, and AHCCCS Technical Interface Guidelines),
 - ii. Diagnostic information including psychiatric, psychological and medical evaluations,
 - iii. Copies of Exhibit 320-8, (see AMPM Policy 320-R) as applicable,
 - iv. An English version of the assessment and/or service plan if the documents are completed in any language other than English, and
 - v. For members receiving services via telemedicine, copies of electronically recorded information of direct, consultative, or collateral clinical interviews.
 - d. Treatment and Service Plan documentation that includes:
 - i. The member's treatment and service plan,
 - ii. Child and Family Team (CFT) documentation,
 - iii. Adult Recovery Team (ART) documentation, and
 - iv. Progress reports or Service Plans from all other additional service providers.
 - e. Progress Note documentation that includes:
 - i. Documentation of the type of services provided,
 - ii. The diagnosis, including an indicator that clearly identifies whether the progress note is for a new diagnosis or the continuation of a previous diagnosis. After a

principal diagnosis is identified, the member may be determined to have co-occurring diagnoses. The service providing clinician will place the diagnosis code in the progress note to indicate which diagnosis is being addressed during the provider session. The addition of the progress note diagnosis code should be included, if applicable,

- iii. The date the service was delivered,
 - iv. The date and time the progress note was signed,
 - v. The signature of the staff that provided the service, including the staff member's credentials,
 - vi. Duration of the service (time increments),
 - vii. A description of what occurred during the provision of the service related to the member's treatment plan,
 - viii. In the event that more than one provider simultaneously provides the same service to a member, documentation of the need for the involvement of multiple providers including the name and roles of each provider involved in the delivery of services,
 - ix. The member's response to service, and
 - x. For members receiving services via telemedicine, electronically recorded information of direct, consultative, or collateral clinical interviews.
- f. Paper or electronic correspondence documentation that includes:
- i. Documentation of the provision of diagnostic, treatment, and disposition information to the PCP and other providers to promote continuity of care and quality management for the member, and
 - ii. Documentation of any requests for and forwarding of behavioral health record information.
- g. Legal documentation including:
- i. Documentation related to requests for release of information and subsequent releases,
 - ii. Copies of any advance directives or mental health care power of attorney:
 - (a) Documentation that the adult member was provided the information on advance directives and whether an advance directive was executed,
 - (b) Documentation of authorization of any health care power of attorney that appoints a designated member to make health care decisions (not including mental health) on behalf of the member if they are found to be incapable of making these decisions,
 - (c) Documentation of authorization of any mental health care power of attorney that appoints a designated member to make behavioral health care decisions on behalf of the member if they are found to be incapable of making these decisions,
 - (d) Documentation of general and informed consent to treatment,
 - (e) Authorization to disclose information,
 - (f) Any extension granted for the processing of an appeal shall be documented in the case file; including the Notice regarding the extension sent to the member and his/her legal guardian or authorized representative.

15. Requirements for Community Service Agencies (CSA), Home Care Training to Home Care Client (HCTC), and Providers and Habilitation Providers:
- a. The Contractor shall require that the clinical records of the CSA, HCTC Provider, and Habilitation Provider conform to the following standards. Each record entry shall be:
 - i. Dated and signed with credentials noted,
 - ii. Legible text, written in blue or black ink, or typewritten, and
 - iii. Factual and correct.
 - b. If required records are kept in more than one location, the agency/provider shall maintain documentation specifying the location of the records. CSAs, HCTC Providers and Habilitation Providers shall maintain a record of the services delivered to each behavioral health member. The minimum written requirement for each behavioral health member's record shall include:
 - i. The service provided and the time increment,
 - ii. Signature and the date the service was provided,
 - iii. The name title and credentials of the member providing the service,
 - iv. The member's CIS identification number and AHCCCS identification number,
 - v. Services are reflected in the behavioral health member's service plan. CSAs, HCTC Providers and Habilitation Providers shall keep a copy of each behavioral health member's service plan in the member's record, and
 - vi. Daily documentation of the service(s) provided and monthly summary of progress toward treatment goals. A summary of the information required in this section shall be transmitted from the CSA, HCTC Provider, or Habilitation Provider to the member's clinical team for inclusion in the comprehensive clinical record.